



Bay Area Orthopedic Surgery and Sports Medicine Bay Area Pain Treatment Center

100 Hospital Drive
Suite 303
Vallejo, CA 94589
Ph: 707-645-7210 Fax: 707-645-7249
www.baosurgery.com
administrator@baosurgery.com

How Are We Doing?

Please take a few minutes to fill out this survey on the timeliness and quality of the service you received today. Bay Area Ortho and Pain welcomes your feedback and your answers will be kept confidential. Thank you for your participation.

General Patient Information

In general, what is the quality of your health?

- Outstanding Good Some chronic issues Poor

How would you rate our concern for your privacy?

- Outstanding Good Adequate Needs improvement Poor N/A

How often have you visited [Healthcare Facility Name] within the past year?

- First Visit 2-5 Visits More than 6

Scheduling Your Appointment

Did you schedule an appointment by phone or did you drop in?

- Scheduled by phone Dropped in

If you scheduled an appointment, did you have to wait longer than expected to get scheduled?

- Yes No

How easy was it to make an appointment by telephone?

- Very easy Very difficult



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How would you characterize the concern that the Medical Staff showed for your problem?

- Outstanding Good Adequate Needs improvement Poor N/A

Did the Medical Staff respond to your requests within a reasonable period?

- Yes No

The Doctor

Did you feel that your doctor spent an adequate amount of time with you?

- Yes No N/A

Mark the boxes that characterize the demeanor of your doctor:

- Attentive Concerned Friendly Distracted Rushed Inconsiderate

How would you rate the competence of your doctor?

- Outstanding Good Adequate Needs improvement Poor N/A

Did you feel that your doctor's examination was thorough?

- Yes No N/A

Please rate the clarity of the doctor's explanation of your condition and treatment options:

- Outstanding Good Adequate Needs improvement Poor N/A

How well did your doctor include you in healthcare decisions?

- Outstanding Good Adequate Needs improvement Poor N/A



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Were your questions answered to your satisfaction?

- Yes No N/A

Would you recommend this facility and its staff to your family and friends?

- Yes No N/A

Additional Feedback

Please list any areas in which our service could be improved.

Please share any additional comments.

Personal Information

Providing the following information is optional.

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Telephone: _____ Gender: _____ Age: _____

Would you like someone to contact you regarding your responses on this survey?

- Yes No

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.